CSSIW NATIONAL INSPECTION SAFEGUARDING AND CARE PLANNING OF LOOKED AFTER CHILDREN AND CARE LEAVERS WHO EXHIBIT VULNERABLE OR RISKY BEHAVIOURS
DATE REPORT RECEIVED: August 2014 **Updated: February 2015**

Area for Improvement	Action Required	Person Responsible	Date to be achieved
1. Did the authority effectively discharge its corporate parenting roles and responsibilities promoting the stability, welfare and safety of looked after children and care leavers?			
1.1 The local authority has not given sufficient regard at a corporate level to the importance of highlighting this group of most vulnerable children and young people. Neither was a profile of this group of children and young people collated and shared across partner agencies and was not available to facilitate strategic service planning for this group of service users.	• Baseline Data Report to be presented to Corporate Parenting Group meeting to identify issues affecting this group of children and young people • Corporate Parenting Group to consider how to raise profile corporately – may consider an annual report to Scrutiny Committee / Cabinet • Review and re-issue Corporate Parenting Handbook to all Elected Members • Appropriate references to be made to this group of children and young people in the revised Commissioning Strategy • Establish links to Corporate Safeguarding Group	JE GJ Corporate Parenting Group	March 2015 March 2015 June 2015 Completed Completed
1.2 We did not see evidence of systems to evaluate the effectiveness of the authority's placement strategy. The current strategy does not include a contemporary analysis of the needs of looked after children or care leavers nor does it outline what actions the authority has planned to manage future need. The range and choice of placements able to meet the assessed needs and promote good outcomes for looked after children and care leavers involved in risky	• Commissioning Strategy being revised • Final version to be launched through staff briefings • Need to ensure it identifies vulnerable LAC, Care Leavers and risky behaviours • Needs to identify range and choice of placements • Needs to link with 5.1 'move on' accommodation for care leavers	DMT	Completed April 2015 Completed Completed Completed

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behaviours was not sufficiently comprehensive as evidenced by the numerous placement moves experienced by some children and young people.			
1.3 Despite good working engagement the resilience of the authority's relationship with health services remain overtly dependant on children's social services providing funding and resources to assess and meet the therapeutic needs of looked after children and care leavers in many cases.	• Links to 2.2 – CAMHS • CSSIW recognise this is a national issue to be addressed on an All Wales basis • Requires 5 Gwent Local Authorities to engage with ABUHB to address findings of Inspections • Gwent HoS to write to Directors to request this is taken forward	See 2.2	Completed
1.4 Arrangements for supporting care leavers in their transition to adulthood were not generally aspirational. Ineffective support and encouragement to access and sustain commitment to available universal services and gaps in provision, particularly supported accommodation, hampered on-going engagement with young adults.	• Awareness raising in respect of aspirational planning through transition processes in 16 plus and CWD Teams • Reinforce role of TOG • Remind IRO's of their responsibilities to ensure adequate transition planning is in place	TB JE CD	Completed
1.5 Although the authority had some mechanisms in place to seek the views and opinions of children/young people about their care, for example through the advocacy services and the Shout Out (care leavers) group, little evidence of how the feedback was used to plan and develop future services.	• NYAS and Shout Out Group to provide periodic reports to the Corporate Parenting on themes and lessons learned from feedback • Young persons representative to be invited to join the Corporate Parenting Group • Consultation processes with IRO's to be monitored and formally reviewed. Links to 4.3 • Implement mobile telephone messaging and text service • Engagement in the consultation phase of the National 'Fostering Changes/ In Good Hands' Programme	JE KJ	Plan in place for June and December meetings June 2015 Completed Completed

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2. Were care and pathway plans informed by relevant assessments, including explicit risk assessments, which supported a comprehensive response to the needs and experiences of children and young people?			
2.1 Despite the range of foster placements available both within and outside the authority boundaries, carers did not always have the skills to effectively safeguard the most complex and vulnerable children and young people nor was there a sufficient level of support for them to achieve this.	• Review of foster carer skills and role of higher level carers including career carers • Review of foster carer training programme • Identify what support services are available for more challenging placements to prevent disruption and breakdown • Make full use of the Gwent wide YOS LAC Protocol to provide additional supports to placements • Fully engage with the national 'Fostering Changes / In Good Hands' Programme	JE SK DMT	June 2015
2.2 There was a significant gap in appropriate services to meet the emotional and psychological health and developmental needs of some children and young people thus creating an over-reliance on social services. There is a recognised longstanding disconnect between the access threshold applied by CAMHS and the presenting emotional resilience needs of looked after children and care leavers. Extensive waiting lists for CAMHS with some not receiving a service to address an assessed therapeutic need at all.	• Links to 1.3 – CAMHS • CSSIW recognise this is a national issue to be addressed on an All Wales basis • Requires 5 Gwent Local Authorities to engage with ABUHB to address findings of Inspections • Gwent HoS to write to Directors to request this is taken forward	Link to 1.3	Completed
2.3 The quality of care plans was variable. Most plans clearly articulated overarching objectives but very few of these were outcome focussed or clear about how risk was to be managed, within what timescales and by whom. The care plans of those children and young people who were	• Improve care planning to include outcomes • Risk management to be monitored through Resources Panel, Permanency Panel and Statutory Reviews • Improve the recording of children and young people's views on case files	DMT	Ongoing

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looked after for long periods were often reliant on informal information exchange between professionals rather than updated written assessments; even in circumstances where there had been significant change. Very few care plans explicitly included the child or young persons views nor had plans routinely been effectively shared with children and/or their families.	• Engagement in SSIA Outcomes Framework pilot and consider roll-out of learning across all teams • Undertake a quality assurance audit of care plans		Pilot February to September 2015 June 2015
3. Were operational systems and procedures in place that ensured responsive co-ordinated action was taken to mitigate risk and achieve continuity of care?			
3.1 Risk assessments and ongoing risk management arrangements, particularly when more than one agency was involved needed to be more effectively recorded, shared and co-ordinated. **3.2** Little evidence on files to support case work consultation between team managers and staff about risk issues.	• Implement a strategic, whole service approach to risk identification, assessment and management using the good practice Risk Model example • Resource training for 2015/16 • Cross reference with QA audit outlined in 2.3 • Lateral checks at 'first contact' to be strengthened by routinely checking: ➢ ICS Hazards ➢ YOS involvement ➢ Violence at Work Register ➢ MIRAF ➢ Probation ➢ Housing	DMT Training	Summer 2015 June 2015
4. Did Independent Reviews and quality assurance arrangements promote safe care and best outcomes for young people?			
4.1 Difficult to evidence from case files IRO challenging arrangements for children and young people.	• Improve recording processes of IRO's to provide written evidence of appropriate challenge of planning and drift between review meetings	CD KJ	June 2015

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4.2 The frequency of tracking between review meetings by IRO was insufficient to ensure actions were completed and as such did not enhance the review process or help counter drift.	• Presentation of 6 monthly and Annual Report on Safeguarding & Review Team to DMT to report on statutory requirements and local priorities highlighted through the Inspection • Review and relaunch the Escalation Protocol where there are professional concerns in relation to care planning		Annual Report in May and 6 monthly report in November each year
4.3 Children and Young people's response to the offer of consultation was poor. Children and young people spoken to advised that they preferred not to attend their reviews as these meetings often made them feel embarrassed and uncomfortable. Reasons included the number of professionals attending the meeting and a perception that although they were invited to express their views these contributions weren't valued. IRO have not sought feedback from children and young people about the review process.	• Endorse the recommendations included in the Consultation report prepared by Senior IRO and presented to DMT October 2014 • Text and messaging service to be established • IRO's to attend Shout Out Group periodically • IRO's to collate themes and issues arising from consultation documents and feedback received and report to DMT through the 6 monthly and Annual Report process	CD KJ	Completed Completed Ongoing
4.4 There were quality assurance arrangements in place but these were insufficiently cohesive to fully capture learning from the review process. A recent lack of capacity had impacted on the effectiveness of the system to influence improvement.	• A service wide Quality Assurance Framework needs to be developed and implemented. • Presentation of 6 monthly Report to DMT for the following service areas: ➢ Safeguarding & Review ➢ Fostering ➢ Ty Ni ➢ IFSS ➢ Immediate Response Team ➢ Legal Proceedings • Thematic audits to be agreed by DMT as need arises	DMT	June 2015 6 monthly reporting cycle
4.5 Commissioning arrangements for children's services were underdeveloped. Where services	• Contract monitoring processes need to be improved	DMT MReid	Ongoing

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had been commissioned, monitoring arrangements were generally confined to contractual matters rather than focussed on broader quality assurance metrics based around outcomes for children and young people.	• Use positive example of steering group to oversee Family Support contract – CD • Implement the revised Commissioning Strategy		April 2015
5. Did care and pathway planning effectively capture and promote the rights and voice of the child?			
5.1 Limitations on placement choice, including appropriate move-on accommodation for care leavers for children and young people with the most challenging and complex needs, frequently militated against meeting the child or young person's wishes and feelings and simultaneously keeping them safe.	• Continue to explore options for 'move on accommodation' with Housing and RSL's • Independent review of use of Ty Ni • Increase recruitment of Supported Lodgings • Revise Fostering Recruitment Strategy • Adopt 'house style' to all marketing	JE	Completed Ongoing April 2015 Completed
5.2 Planning in relation to involvement in sporting leisure and/or community based activities was inconsistent.	• Reinforce Foster Carers role in promoting leisure activities • Engagement of 16 Plus Team with Youth Service and Leisure • Make explicit reference to leisure activities in Pathway Planning • Role of IRO's to monitor through reviews	JE KJ	